Refeeding Patients with Eating Disorders

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September 19, 2025

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McLean
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Disclosures

I have no conflicts of interest to disclose.

Eating Disorders in the US

- Why should I learn about this?

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Strategic Training Initiative for the Prevention of Eating Disorders

AED
Academy *for* Eating Disorders

1. Mortality

10,200 deaths per year as a direct result of an eating disorder, equating to 1 death every 52 minutes

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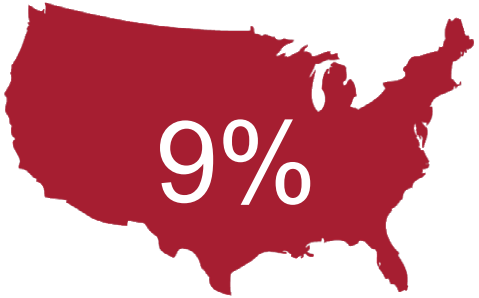
2. Prevalence



Percent of the US population,
or 28.8 million Americans,
that will have an eating
disorder in their lifetime

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3. Costs

$64.7 Billion } Yearly economic cost of eating disorders

Additional loss of wellbeing per year { $326.5 Billion

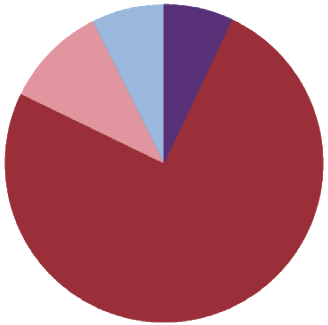
Cost Breakdown:

Productivity Losses ($48.6B)

Informal Care ($6.7B)

Efficiency Losses ($4.8B)

Health System ($4.6B)



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4. Wide Reach

EATING DISORDERS AFFECT EVERYONE:

- All ages, starting as young as 5 years old to over 80 years old
- All races, however, people of color with eating disorders are half as likely to be diagnosed or to receive treatment
- All genders, with females being 2x more likely to have an eating disorder
- All sexual orientations

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Eating Disorders in the US

- Early recognition and treatment are crucial to recovery
- Access to care for patients can be limited
- Access to training for providers can be limited

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Today's Talk

- Focus on general principles **applicable across different settings**
- Select topics, not comprehensive review

Overview

- Who: refeeding **underweight patients** with restrictive EDs
- Where: **level of care** for refeeding
- How: ensuring **medical safety** during refeeding
- To refeed or not to refeed: **ethics**

Refeeding

Refeeding

- Definition: nutritional rehabilitation aimed at weight restoration of **underweight patients with EDs**

DSM-5 Feeding and Eating Disorders

- **Anorexia Nervosa (AN)**
- Bulimia Nervosa (BN)
- Binge Eating Disorder (BED)
- Other Specified Feeding and Eating Disorder (OSFED)
- Avoidant Restrictive Food Intake Disorder (ARFID)
- Unspecified Feeding and Eating Disorder (UFED)
- Pica
- Rumination Disorder

Only AN has a **weight criterion**

Anorexia Nervosa

Table 1. Diagnostic Criteria for and Subtypes and Severity of Anorexia Nervosa.

Diagnostic criteria*

Restriction of energy intake relative to requirements, leading to significantly low body weight for the patient's age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than the minimal normal weight or, in children and adolescents, less than the minimal expected weight.

Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though the patient has a significantly low weight.

Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Extreme restriction resulting in **low body weight**

Behaviors (or **fears** driving behaviors) that interfere with weight gain

Cognition
overvaluation of weight or shape, or lack of insight

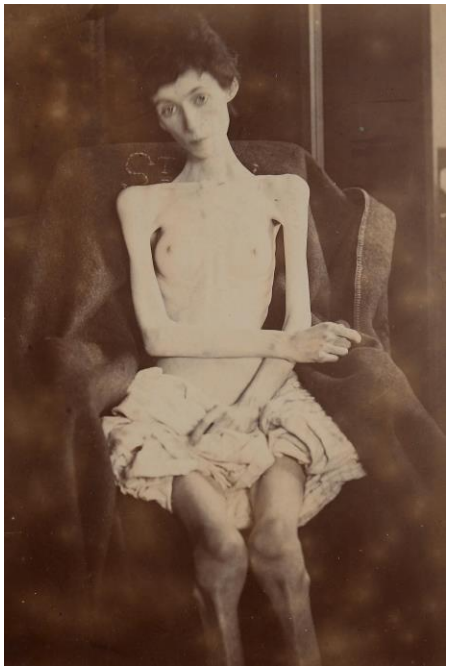
References
DSM-5 (2013). APA.
Michell JE and Peterson CB (2020). Anorexia Nervosa. NEJM.

Anorexia Nervosa

Severity specifier:

- Mild (BMI 17-18.49)
- Moderate (BMI 16-16.99)
- Severe (BMI 15-15.99)
- Extreme (BMI < 15)

Can be modified to match the clinical severity



Woman suffering from anorexia nervosa.
St. Bartholomew's Hospital Archives & Museum.

Anorexia Nervosa

- One of the **highest mortality rates** in psychiatry (6x)
- **Chronic** course of illness with high **morbidity**
- Medical complications
  - Electrolyte abnormalities
  - Reproductive failure
  - Gastrointestinal motility/obstructive disorders
  - Osteoporosis
  - Cardiac arrythmias/heart failure
  - **Death**
- Psychiatric comorbidities/complications
  - Depression/**TRD** (limited antidepressant response, 20x suicide risk)
  - Anxiety
  - Poor sleep and energy
  - Impaired quality of life and social withdrawal

Refeeding

- Definition: nutritional rehabilitation aimed at weight restoration of **underweight patients with EDs**
- Objective: **full recovery**

Refeeding

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(1) Weight restoration

(2) Weight maintenance

Refeeding

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(1) **Weight restoration: refeeding**

(2) Weight maintenance

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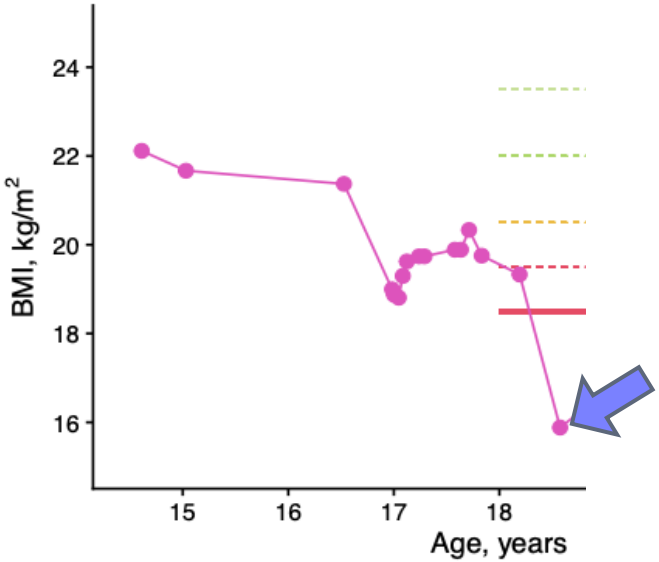
(1) **<u>Weight restoration</u>: refeeding**

(2) Weight maintenance



Anorexia Nervosa

Cognitions
Over-evaluation of body image, shape, and weight
"Nothing tastes better than skinny feels"

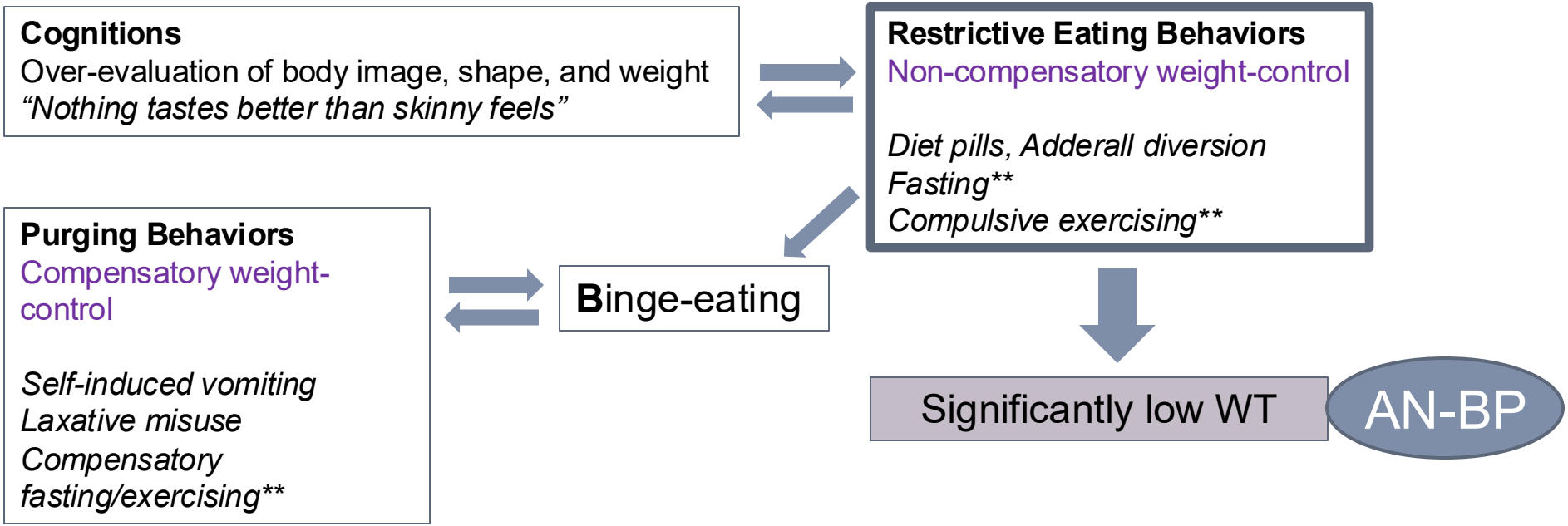
Restrictive Eating Behaviors
Non-compensatory weight-control

Diet pills, Adderall diversion
*Fasting***
*Compulsive exercising***

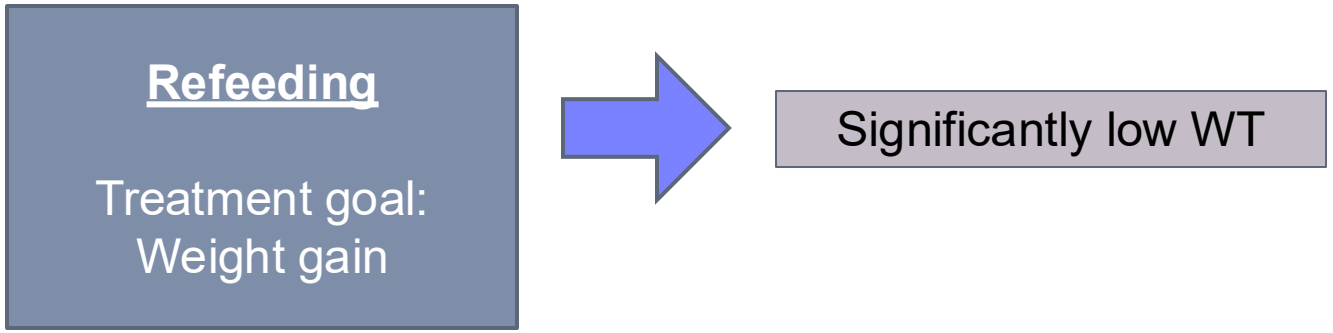
Significantly low WT

AN-R

Anorexia Nervosa



Anorexia Nervosa



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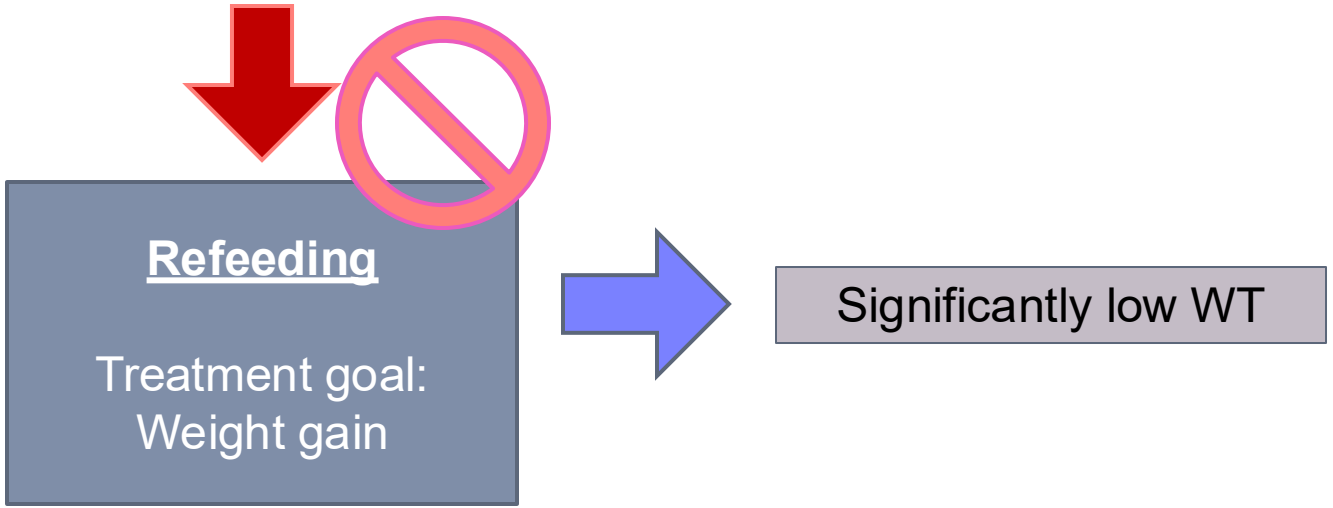


Refeeding

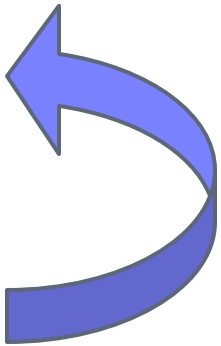
- Definition: nutritional rehabilitation aimed at weight restoration of **underweight patients with EDs**

- Objective: **full recovery**

(1) Weight restoration: refeeding

(2) **Weight maintenance**

high relapse rates – up to 50% of adult patients require re-admission within a year of discharge



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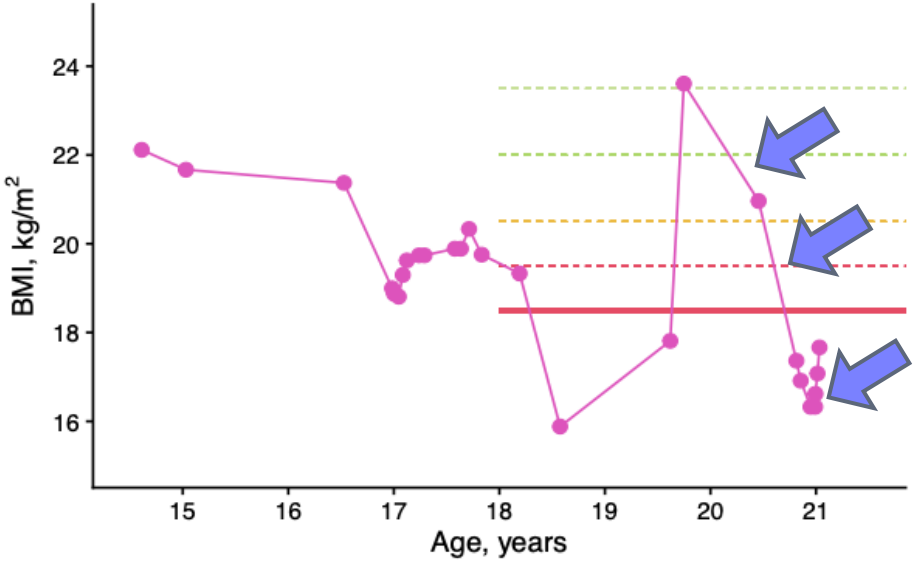
- Definition: nutritional rehabilitation aimed at weight restoration of **underweight patients with EDs**
- Objective: **full recovery**

(1) **<u>Weight restoration</u>: refeeding**

(2) Weight maintenance



Levels of Care

Levels of Care

- Understanding LOCs is **key to patient safety** & **effective treatment**

Levels of Care

Outpatient (OP)

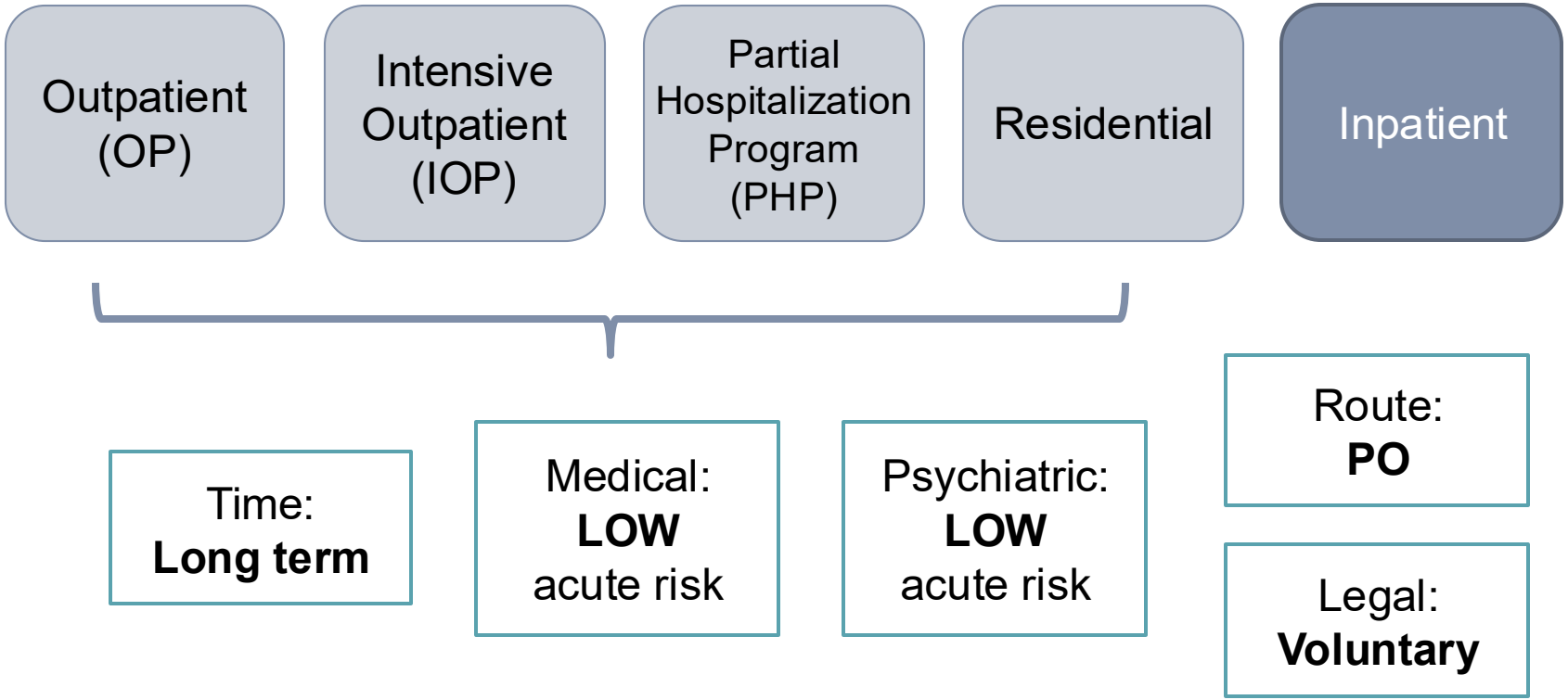
Intensive Outpatient (IOP)

Partial Hospitalization Program (PHP)

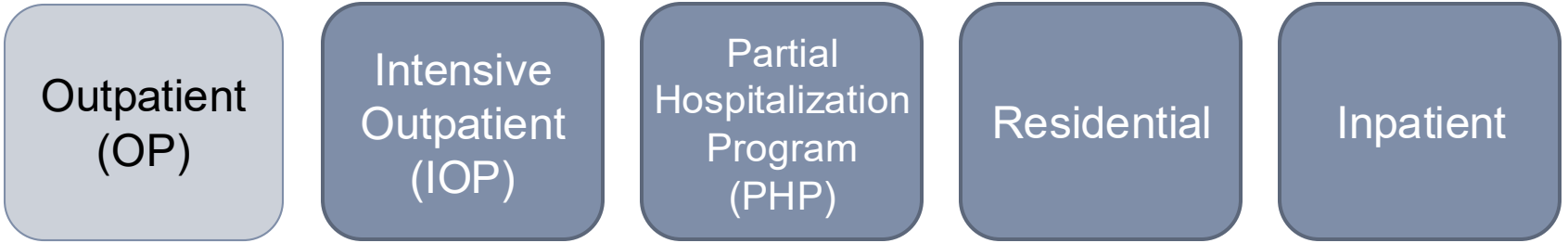
Residential

Inpatient

Levels of Care: Community



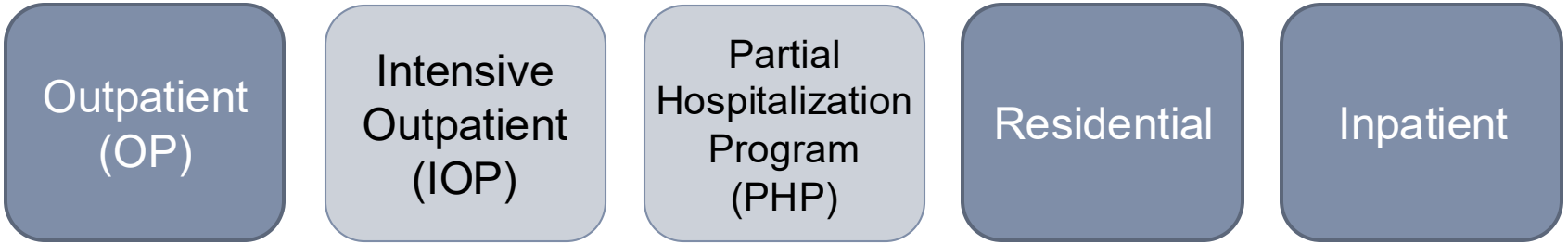
Levels of Care: Community



- **Clinical need:** 1-5 hours/week (<10 hours/week)
- **Therapy**: individual, ± psychiatrist, ± family, ± dietitian
- **Medical monitoring**: PCP, psychiatrist, adolescent medicine

Long term
10-40+ weeks

Levels of Care: Community

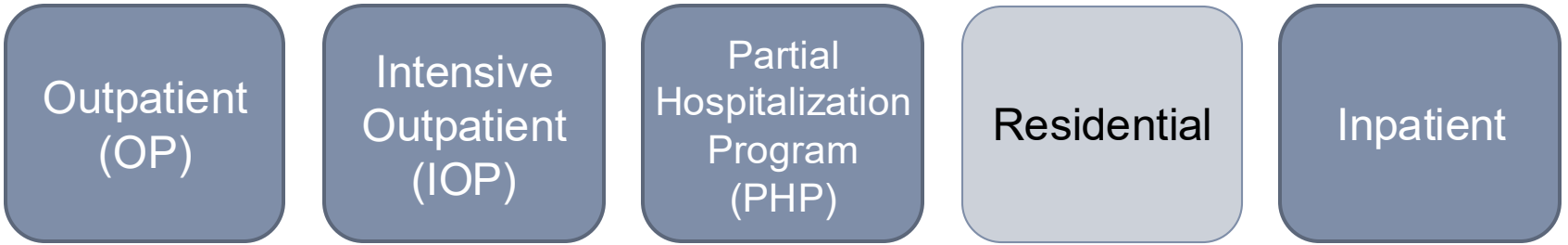


- **Clinical need:**
  - IOP: 4-6 hours/day x 3 days/week (12-18 hours/week)
  - PHP: 6-9 hours/day x 5 days/week (30-45 hours/week)

Long term
4-12 weeks

- **Therapy**: **group**, individual, ± psychiatrist, ± family, ± dietitian
- **Medical monitoring**: ≤1x times/week

Levels of Care: Community

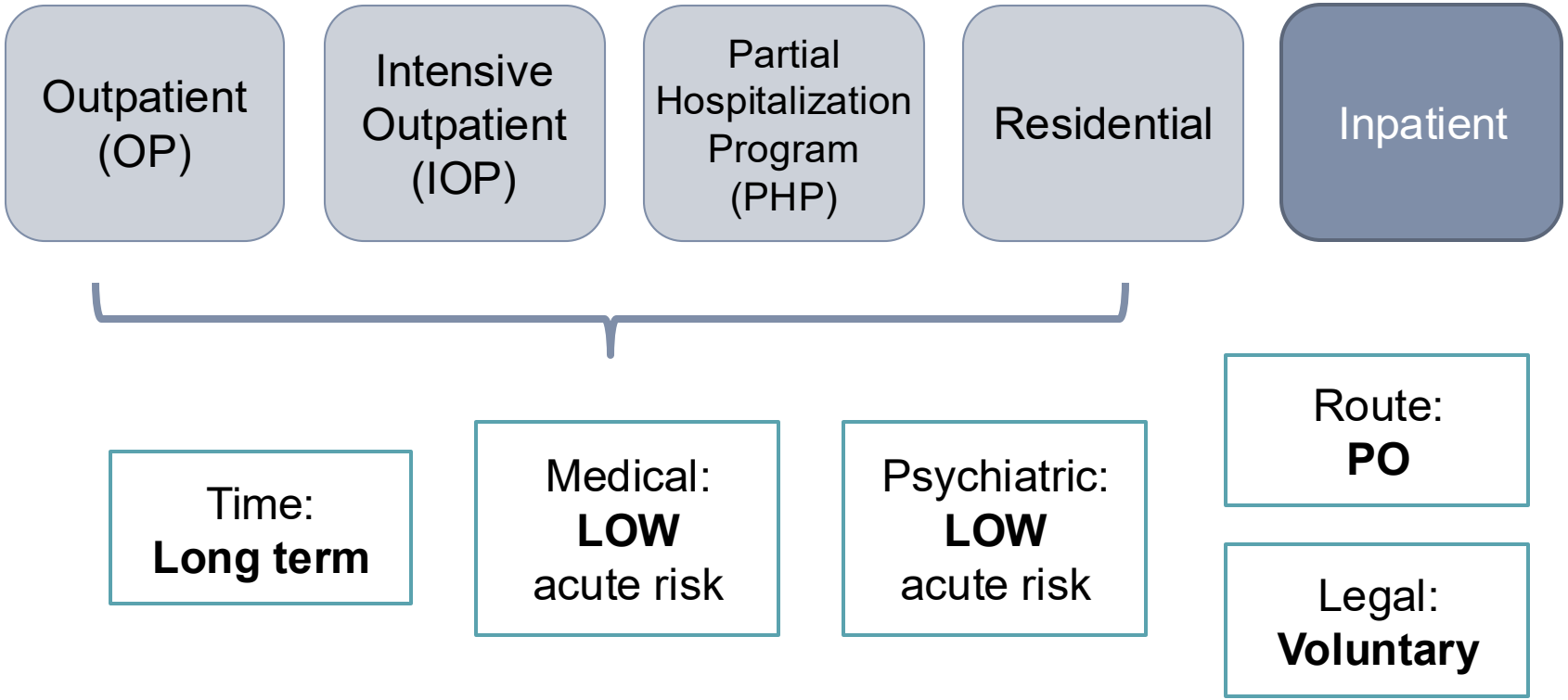


- **Clinical need:** 24/7 behavioral structure/supervision
  - Patient *residence* + appointments in the community

Long term
4-12 weeks

- **Therapy**: **group**, individual, psychiatrist, family, dietitian
- **Medical monitoring**: ≥1x times/week

Levels of Care: Community



Levels of Care: Key Questions

- Diagnosis made → AN
- **Triaging LOC?**

Levels of Care: Key Questions

Legal:
Voluntary

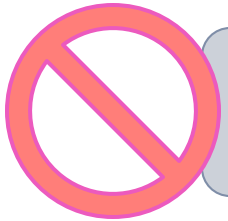
Willing and ready to engage in refeeding protocol voluntarily?

Levels of Care: Key Questions

Legal:
Voluntary

Willing and ready to engage in refeeding protocol voluntarily?

No?

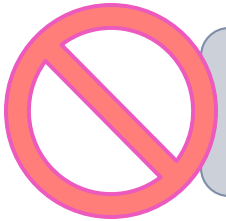


Community LOC *for refeeding*

We will return to this topic at the end

Levels of Care: Key Questions

Legal: **Voluntary**	Willing and ready to engage in refeeding protocol voluntarily?	**Yes**
Route: **PO**	Able to feed sufficiently PO?	**No?**

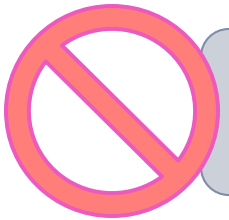


Community LOC for refeeding

Trial of tube feeding via NG tube

Levels of Care: Key Questions

Legal: **Voluntary**	Willing and ready to engage in refeeding protocol voluntarily?	**Yes**
Route: **PO**	Able to feed sufficiently PO?	**Yes**
Psychiatric: **LOW** acute risk	Is the imminent risk of harm sufficiently mitigated? e.g. active SI, violence or severe agitation with refeeding, florid mania/psychosis due to malnutrition	**No?**



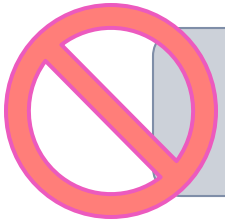
Community LOC for refeeding

Levels of Care: Key Questions

Medical:
LOW
acute risk

Are they medically stable?

No?



Community
LOC

Levels of Care: Key Questions

Medical:
LOW
acute risk

Are they medically stable?

Refeeding: Medical Safety

Medical:
LOW
acute risk

Are they medically stable?

- VS abnormalities: severe/symptomatic
  - hypotension, bradycardia, tachycardia, orthostasis, hypothermia

Refeeding: Medical Safety

Medical:
LOW
acute risk

Are they medically stable?

- VS abnormalities: severe/symptomatic
  - hypotension, bradycardia, tachycardia, orthostasis, hypothermia
- **Weight < 75 %IBW or roughly < BMI 16 **

Refeeding: Medical Safety

Medical:
LOW
acute risk

Are they medically stable?

- VS abnormalities: severe/symptomatic
  - hypotension, bradycardia, tachycardia, orthostasis, hypothermia

- **Weight < 75 %IBW or roughly < BMI 16 **
  - With the right team in the community, including adequate medical monitoring, AND for the right patient/family, individuals with very low body weights can be safely weight restored in the community…

Refeeding: Medical Safety

Medical:
LOW
acute risk

Are they medically stable?

- Severe VS abnormalities
- Very low body weight

Refeeding: Medical Safety

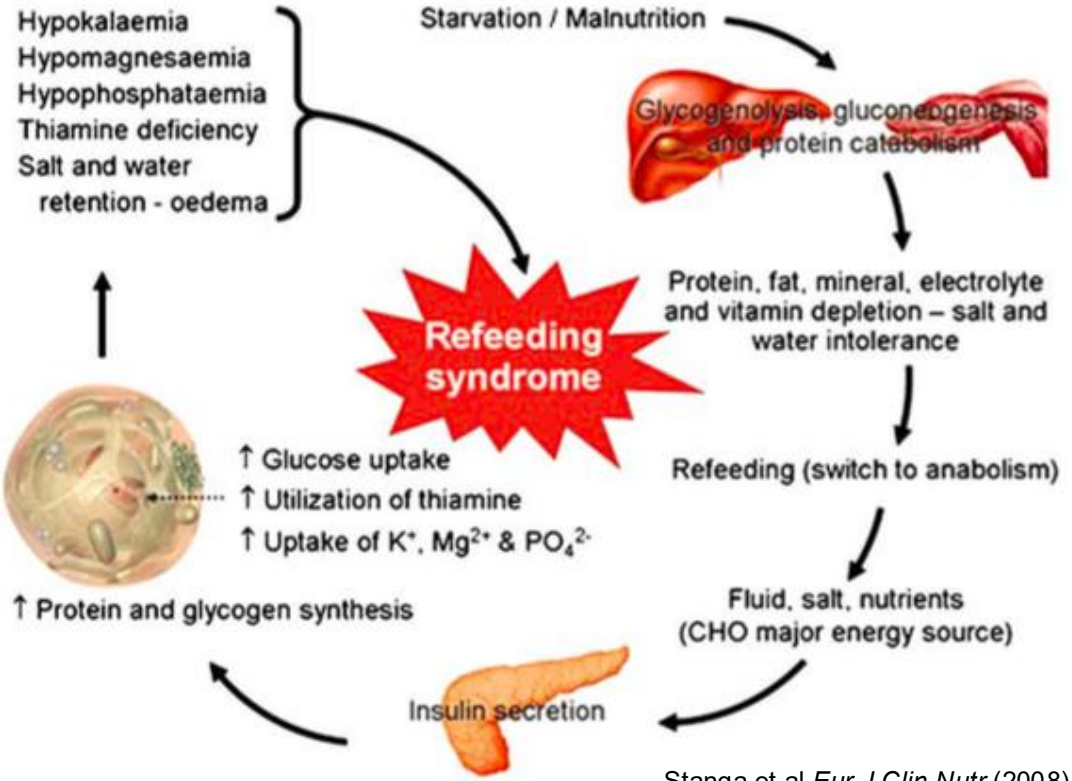
Medical:
LOW
acute risk

Are they medically stable?

- Severe VS abnormalities: aka need for telemetry
- Very low body weight: aka electrolyte monitoring capacity
  - Multiple times daily? (severe abnormalities) → Inpatient
  - Up to once a day? → Community

Both are related to the cardiac risk

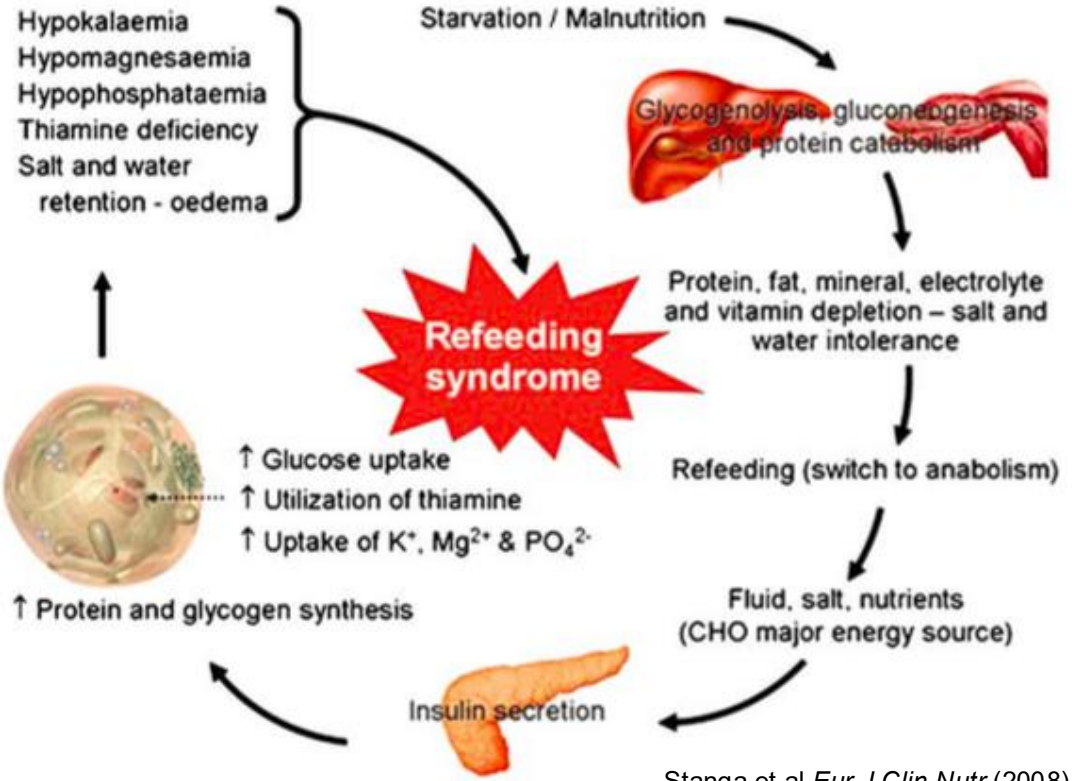
Refeeding Syndrome (RFS)



Stanga et al *Eur J Clin Nutr* (2008)

Refeeding Syndrome (RFS)

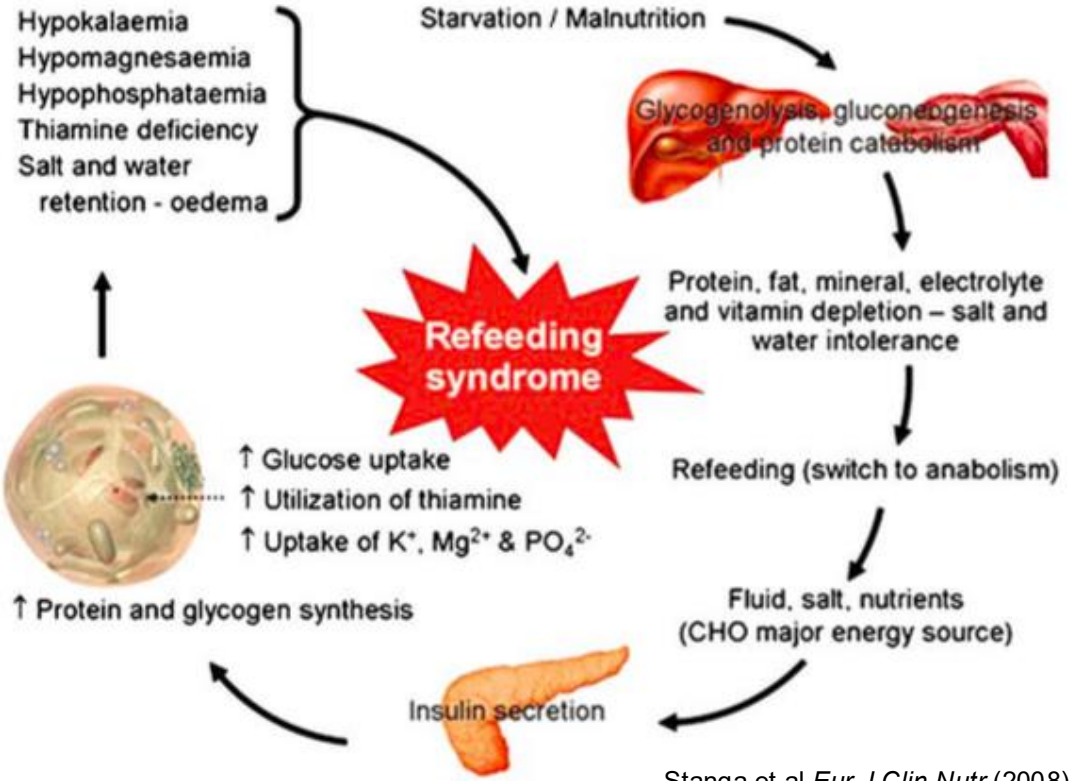
- Risk is highest in the first 7-21 days **transitioning from starvation to refeeding**



Stanga et al *Eur J Clin Nutr* (2008)

Refeeding Syndrome (RFS)

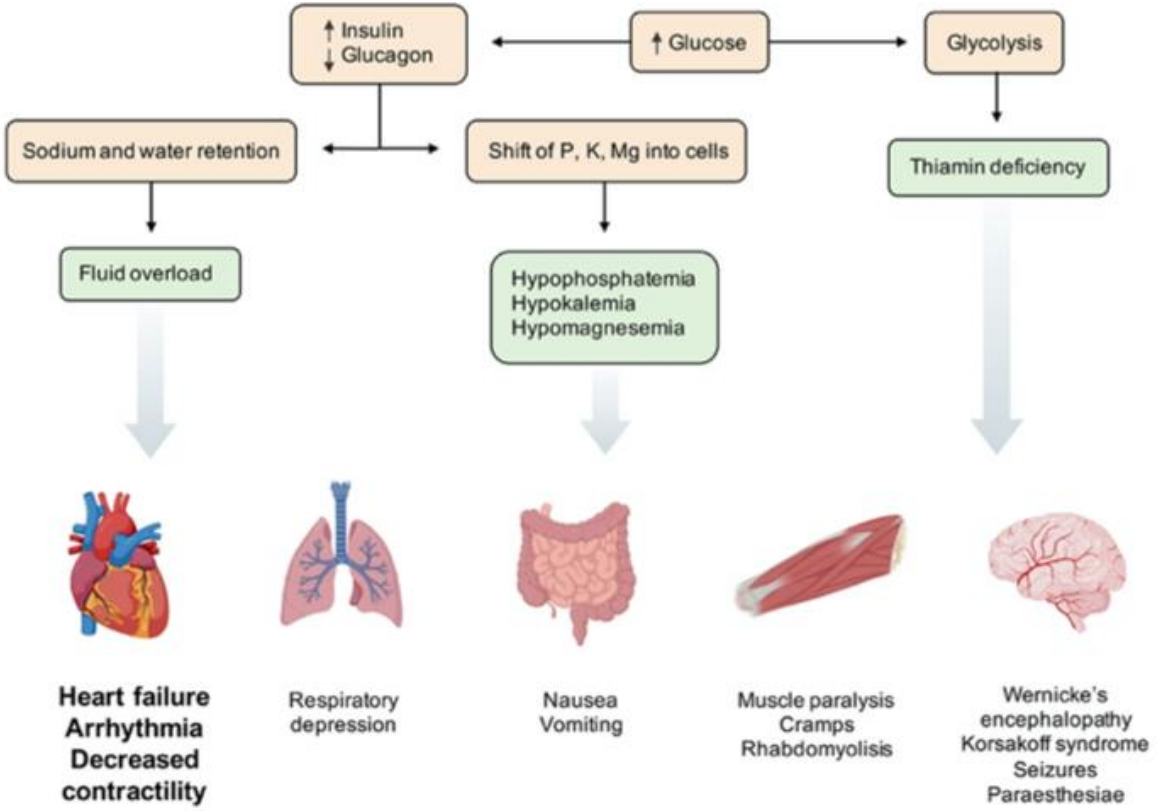
- Risk is highest in the first 7-21 days **transitioning from starvation to refeeding**
- Insulin surge → electrolytes and fluid shift from extra to intracellular space as cells take up glucose



Stanga et al *Eur J Clin Nutr* (2008)

Refeeding Syndrome (RFS)

How do we minimize the risk of RFS?



Fernández-Pombo et al *Clin Nutr* (2021)

Refeeding: Medical Safety

- **Replete electrolytes** to prevent and treat early RFS
  - K ≥ 3.5 or ≥ **4.0 mEq/L**
  - Mg ≥ 1.7 or ≥ **2.0 mg/dL**
  - Phos ≥ **3.0 mg/dL**
  - Example schedule: BMP, Mg, Phos on days **1,** *2, 3,* **4, 7,** *10,* **14,** *21*

Refeeding: Medical Safety

- **Replete electrolytes** to prevent and treat early RFS
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Cardiac goals:

K, Mg, Phos to 4.0, 2.0, 3.0

Refeeding: Medical Safety

- **Replete electrolytes** to prevent and treat early RFS
  - K ≥ 3.5 or ≥ **4.0 mEq/L**
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  - Example schedule: BMP, Mg, Phos on days **1,** *2, 3,* **4, 7,** *10,* **14,** *21*

- **Supplement as prophylaxis**
  - Multivitamin with iron daily
  - Thiamine 100 mg daily x 7-10 days
  - Folate 1 mg daily x 7-10 days
  - PhosNaK 250 mg x 7-10 days

Refeeding: Medical Safety

- **Replete electrolytes** to prevent and treat early RFS
  - K ≥ 3.5 or ≥ **4.0 mEq/L**
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- **Supplement as prophylaxis**
  - Multivitamin with iron daily
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  - Folate 1 mg daily x 7-10 days
  - PhosNaK 250 mg x 7-10 days

- **Treat if deficient**
  - Vitamin D3 1000-2000 IU daily
  - Mg Oxide 400 mg BID-TID
  - PhosNaK (1-2 packets BID-TID)

Refeeding: Medical Safety

- Caveat
  - Patients with AN can have sporadic electrolyte abnormalities when they are starving/restricting or related to purging.
  - This is NOT refeeding syndrome.
  - **One cannot develop RFS if they haven't started refeeding!**

Refeeding: Medical Safety

For a low weight patient with AN actively engaging in a community LOC and continuing to meet the following:

Psychiatric:
LOW
acute risk

Route:
PO

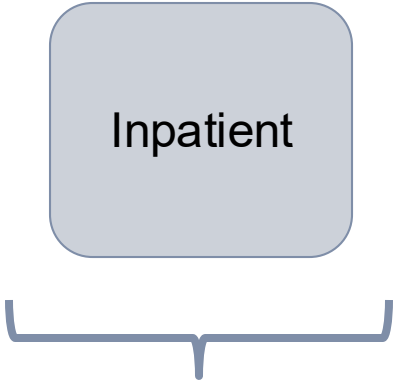
Legal:
Voluntary

LOC Q for medical status primarily involves serial evaluation for:

Is the acute medical risk of RFS sufficiently mitigated to continue care in the community LOC?

Fernández-Pombo et al *Clin Nutr* (2021)

Levels of Care: Inpatient



Levels of Care: Inpatient

	Acute medical risk is HIGH	Acute psychiatric risk is HIGH	Weight is very LOW	Requires an NGT	Long term ED treatment
Inpatient **Psychiatry**	NO	**YES**	NO**	NO	NO
Inpatient **Medical Psychiatry**	NO**	**YES**	**YES**	Ideally, NO	NO
Inpatient **Medicine**	**YES**	Ideally, NO	**YES**	**YES**	Ideally, NO
Inpatient **Eating Disorders**	*Depends*	**YES**	**YES**	*Depends*	**YES**

Refeeding: Treatment Components

- So, how do we refeed patients with AN?

Refeeding: Treatment Components

- Big picture overview

Refeeding: Treatment Components

- Big picture overview

1. Medical monitoring

Refeeding: Treatment Components

- Big picture overview

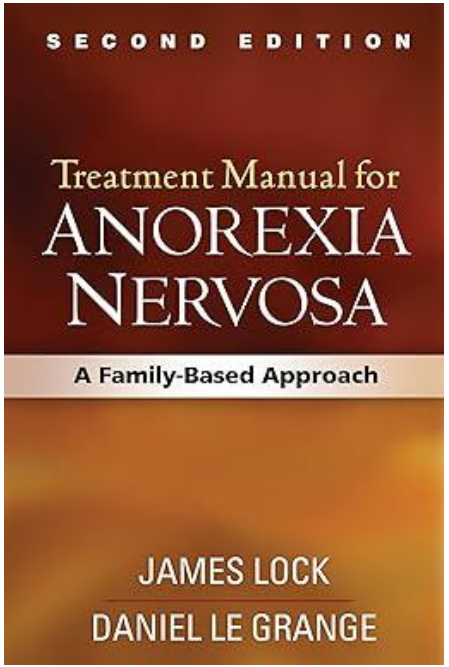
1. Medical monitoring
2. **Motivate behavioral change to weight restore fully by regular eating**

Refeeding: Treatment Components

- Big picture overview

1. Medical monitoring
2. **Motivate behavioral change to weight restore fully**

    - Family-based treatment for AN (FBT-AN)
      Fair evidence for adolescents with AN

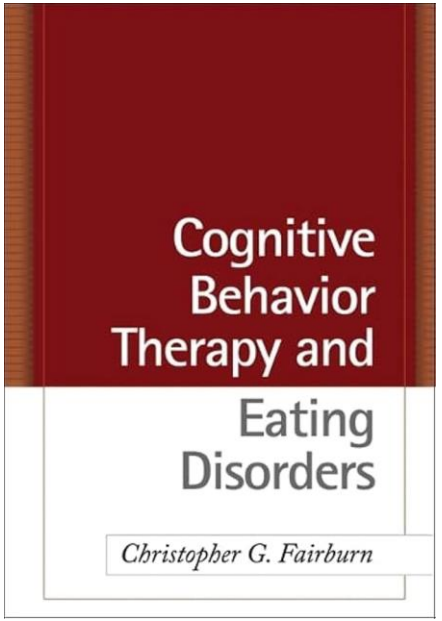


Refeeding: Treatment Components

- Big picture overview

1. Medical monitoring
2. **Motivate behavioral change to weight restore fully**

    - Enhanced Cognitive Behavioral Therapy (CBT-E)



Refeeding: Treatment Components

- Big picture overview

1. Medical monitoring
2. **Motivate behavioral change to weight restore fully by regular eating**

    - Reality: for adults with AN, no psychotherapy modality has demonstrated robust efficacy

Refeeding: Treatment Components

- Big picture overview

1. Medical monitoring
2. **Motivate behavioral change to weight restore fully by regular eating**

    - Reality: for adults with AN, no psychotherapy modality has demonstrated robust efficacy

    - Reality: when starting refeeding, **patients need MI + psychoeducation to enact a behavioral change**

Refeeding: Treatment Components

- Big picture overview

1. Medical monitoring
2. **Motivate behavioral change to weight restore fully by regular eating**

Combination of C**B**T + MI

Addressing food restriction is not so unlike addressing medication nonadherence

Refeeding: Treatment Components

- Big picture overview

1. Medical monitoring
2. **Motivate behavioral change to weight restore fully by regular eating**

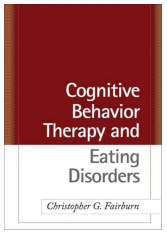
Refeeding: Treatment Components

- Big picture overview

1. Medical monitoring
2. **Motivate behavioral change to weight restore fully by regular eating**

Definition: 3 Meals + 2-3 Snacks
3-4 hours between each meal or snack

Variation of **regular eating** at all LOC for refeeding



Refeeding: Treatment Components

- Big picture overview

1. Medical monitoring
2. Motivate behavioral change to weight restore fully by regular eating
3. **Weight monitoring and calibrating caloric intake to make progress in weight gain**

Refeeding: Weight Goal

Weight goal is generally **90-110% Ideal Body Weight (IBW)** or >BMI 20

It is critical to set a **sufficiently high** weight goal as end-treatment weight status (or BMI) is one of the few **modifiable** risk factor for relapse in AN*

*Sala M et al. "Predictors of relapse in eating disorders: a meta-analysis." *J Psychiatric Research (2023).*

Refeeding: Weight Goal Example

Weight goal is generally **90-110% Ideal Body Weight (IBW)** or >BMI 20

1. Obtain height, weight, and Body Mass Index (BMI) or BMI percentile

   40 kg 88 lbs
   1.60 m 5'3"

   BMI = (weight in kg) / (height in m)^2
   40 kg / (1.60 m)^2 = 15.6 kg/m^2

2. Obtain IBW from BMI at 50th percentile for age (growth chart) x height^2

   Adults, BMI 21.7
   IBW = (21.7 kg/m^2) x (1.60 m)^2 = 55.6 kg

3. Obtain %IBW to monitor status/progress

   %IBW = (weight in kg) / (IBW in kg) x 100% = 40 kg / 55.6 kg x 100% = 72%

Refeeding: Weight Monitoring

- Weighing oneself too often or avoidance of weighing are both problematic
  - Frequent Weighing
    - Increases preoccupation with shape/weight
    - Fluctuations in weight impact patient's mood/overall functioning
  - Avoidance of Scale ("Blind Weights" in clinical settings?)
    - Increases preoccupation with shape and weight
    - Increases shame/fear associated with weight
    - Prevents patient from accessing information regarding treatment progress
- **In session weights**

**Sala M et al. "Predictors of relapse in eating disorders: a meta-analysis." J Psychiatric Research (2023).*

Refeeding: Caloric Goal

Goal is generally 3000-4500 kcal/day **to achieve 2-5 lbs gain/week**

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How do we get here from baseline of restriction (eg <500 kcal/day)?

Refeeding: Caloric Goal

- Lower-calorie refeeding (LCR)[1-3]
  - Start at 800-1400 kcal/day and increase slowly
  - Rationale: minimize refeeding syndrome (RFS) risk

1. APA. Practice guideline for the treatment of patients with eating disorders (revision). *Am J Psychiatry* (2000).
2. ADA. Position of the American Dietetic Association: nutrition intervention in the treatment of anorexia nervosa, bulimia nervosa, and other eating disorders. *J Am Diet Assoc* (2006).
3. Stanga Z et al. *Eur J Clin Nutrition* (2008).

Refeeding: Caloric Goal

- Lower-calorie refeeding (LCR)[1-3]
  - Start at 800-1400 kcal/day and increase slowly
  - Rationale: minimize refeeding syndrome (RFS) risk

  - Cons: "Underfeeding syndrome"[4] ?
    Protracted LOS/slower progress in weight gain
    Lower rates of remission, higher mortality

1. APA. Practice guideline for the treatment of patients with eating disorders (revision). *Am J Psychiatry* (2000).
2. ADA. Position of the American Dietetic Association: nutrition intervention in the treatment of anorexia nervosa, bulimia nervosa, and other eating disorders. *J Am Diet Assoc* (2006).
3. Stanga Z et al. *Eur J Clin Nutrition* (2008).
4. MARSIPAN Working Group. Management of really sick patients with anorexia nervosa. (2010) (2014 2nd ed).

Refeeding: Caloric Goal

- Higher-calorie refeeding (HCR)[1-3]
  - Start at 2000 kcal/day and increase rapidly
  - Study of Refeeding to Optimize Inpatient Gains (StRONG RCT at UCSF/Stanford)
    - No increased risk of RFS with HCR vs LCR protocols in inpatient settings
  - **Applicability to lower LOC?**

1. Garber et al. *JAMA Peds* (2021).
2. Golden et al. *Pediatrics* (2021).
3. Garber et al. *Int J Eating Disorders* (2024).

Refeeding: Treatment Components

- Big picture overview

1. Medical monitoring
2. Motivate behavioral change to weight restore fully by regular eating
3. Weight monitoring and calibrating caloric intake to make progress in weight gain

Family/supports involvement

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Psychopharmacology

Refeeding: Psychopharmacology

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- AN: **no FDA-approved meds**

Refeeding: Psychopharmacology

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  Off-label use of mirtazapine and antipsychotics* to **help with weight gain**

  *Attia et al. Olanzapine in AN RCT. *Am J Psychiatry* (2019)

  +Modest effect size on weight gain

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  Off-label use of antidepressants for mood/anxiety?

  Off-label use of benzodiazepines for meal-time anxiety?

  *Steinglass J et al. Alprazolam in AN RCT. *Int J Eat Disorders* (2014)

  No reduction in meal-time anxiety

  No increase in meal intake

  Increased fatigue

Refeeding: Summary

Medical:
LOW
acute risk

Psychiatric:
LOW
acute risk

Route:
PO

Legal:
Voluntary

Community
LOC *for refeeding*

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Medical
monitoring

Weight
restoration

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Community LOC *for refeeding*

Medical monitoring

Weight restoration

Refeeding sufficiently to gain weight	Motivating behavioral change
Psychopharmacology	Family

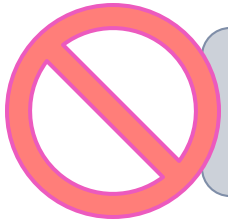
Decision to Refeed

Levels of Care: Key Question Revisited

Legal:
Voluntary

Willing and ready to engage in refeeding protocol voluntarily?

No?



Community LOC *for refeeding*

We will return to this topic at the end

Levels of Care: Key Question Revisited

Legal:
Voluntary

Willing and ready to engage in refeeding protocol voluntarily?

No?

Community LOC *for refeeding*

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For patients who are not willing to weight restore, where do we go?

Decision to Refeed

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26 yo F patient. Struggling with anorexia nervosa since age 13.

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Severe depression. Passive SI. No recent SA.

Current BMI at 13, lowest lifetime weight.

Past years of treatment with waning motivation + increasing difficulty in fully weight restoring.

Routine labs and vital signs are not concerning for acute medical compromise.

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- Persistent AN/ED
- “Treatment-resistant” AN/ED
- “Treatment-refractory” AN/ED
- Severe and enduring AN/ED
- “End-stage” AN/ED

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But AN is a chronic illness…?

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- “Treatment-refractory” AN/ED
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Eddy KT et al. *J Clin Psychiatry* (2017).
After 9 years of follow-up, 1/3 of patients with AN were recovered.
After 22 years of follow-up, 2/3 of patients with AN were recovered.

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After 22 years of follow-up, 2/3 of patients with AN were recovered.

AN is a chronic illness

Decision to Refeed

- If patient is not willing to engage in refeeding voluntarily…
  - do you implement **treatment over objection** (TOO)?

- If repeated cycles of refeeding has failed…
  - do you stop and adopt a **harm-reduction approach**?

Decision to Refeed

- If patient is not willing to engage in refeeding voluntarily…
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Decision
To refeed whether or not patient wants this

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Rationale

Life-saving measure

Decision making about eating impaired due to AN pathology

Decision to Refeed

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  - do you implement **treatment over objection** (TOO)?

Decision
To refeed whether or not patient wants this

Rationale	Priorities
Life-saving measure Decision making about eating impaired due to AN pathology	Beneficence Non-maleficence* Justice* > Autonomy

Decision NOT to TOO → Death: Ethics?

- If patient is not willing to engage in refeeding voluntarily…
  - do you implement **treatment over objection** (TOO)?

The ethics of forced feeding in anorexia nervosa

Philip C. Hébert, MD, PhD, CCFP; Michael A. Weingarten, MA, BM, DPH

Futility of treatment? DNR/advanced directive? “hopelessly ill” patients…

CMAJ 1991

Decision NOT to Refeed

- If patient is not willing to engage in refeeding voluntarily…
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Decision
To NOT refeed despite the risks of low body weight

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Rationale

Treatment trauma

Outcomes of compulsory treatment

Decision NOT to Refeed

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Decision
To NOT refeed despite the risks of low body weight

Rationale

Treatment trauma

Outcomes of compulsory treatment

Priorities

Autonomy
Non-maleficence*
>
Beneficence
Justice

Decision NOT to Refeed

- If patient is not willing to engage in refeeding voluntarily…
  - do you implement **treatment over objection** (TOO)?

- If repeated cycles of refeeding has failed…
  - do you stop and adopt a **harm-reduction approach**?

Can patients consent to this as a treatment approach?

To Refeed or Not to Refeed

- If patient is not willing to engage in refeeding voluntarily…
  - do you implement **treatment over objection** (TOO)?

- If repeated cycles of refeeding has failed…
  - do you stop and adopt a **harm-reduction approach**?

Thank you for your attention!